General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Barkers Chemist, The Portacabin, 245 Garratt Lane, London, SW18 4DU

Pharmacy reference: 9011803

Type of pharmacy: Community

Date of inspection: 17/11/2022

Pharmacy context

This is a busy NHS community pharmacy set next door to a health centre on the outskirts of Earlsfield and Wandsworth. The pharmacy opens six days a week. It sells over-the-counter medicines. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy supplies multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. It provides a substance misuse treatment service. And people can get their flu vaccination (jab) and have their blood pressure (BP) checked at the pharmacy.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they review and talk to each other about the mistakes they make. So, they can learn from them and try to stop the same sort of things happening again.

Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, as a result, it put some plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team had the personal protective equipment they needed. And hand sanitising gel was available for them to use too. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were kept on the computer and were reviewed by a team at the pharmacy's head office. Team members were required to read and sign the online SOPs relevant to their roles to show they understood them and agreed to follow them. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the responsible pharmacist (RP). The pharmacy team highlighted and separated a few medicines which were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). And its team members discussed, reviewed and recorded the mistakes they made to learn from them and reduce the chances of them happening again.

The pharmacy displayed a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. People shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets and an in-store notice which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a computerised controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs required. The pharmacy kept records of the supplies of the unlicensed medicinal products it made. But these were incomplete. The pharmacy had a record to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incorrect in the private prescription records and

the reason for making an emergency supply wasn't always recorded properly.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. And it had an information governance policy which its team needed to read. The pharmacy had a safeguarding policy. Members of the pharmacy team had the contacts they needed if they wanted to raise a safeguarding concern. And they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough people in its team to deliver safe and effective care. But its team sometimes doesn't get time to do all the things it's expected to do. Members of the pharmacy team do the right training for their roles. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy and its services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The regular pharmacy team consisted of a pharmacist manager, a locum pharmacist, a full-time dispensing assistant, a part-time dispensing assistant, a full-time trainee dispensing assistant, a part-time medicines counter assistant, two part-time trainee medicines counter assistants and a part-time delivery driver. The locum pharmacist (the RP), two dispensing assistants and a trainee dispensing assistant were working at the time of the inspection. The pharmacy had a vacancy for another team member to work in the dispensary after an experienced team member left. The pharmacy relied upon its team, locum dispensers, locum pharmacists and team members from one of the company's other pharmacies to cover absences. Members of the pharmacy team were up to date with their workload and helped each other to serve people and dispense prescriptions safely. But they sometimes struggled to do all the things they were expected to do.

The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to the pharmacist on duty. People working at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their line manager when they could. They shared learning from the mistakes they made when the pharmacy was quieter. And they were encouraged to complete training to try and keep their knowledge up to date. But they often trained or did other tasks in their own time. Members of the pharmacy team didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to them rostering their tasks more effectively.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and a secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy premises were air-conditioned, bright, clean, secure and tidy. And they were professionally presented. The pharmacy generally had the workbench and storage space it needed for its current workload. The pharmacy had a consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was usually locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team and a cleaner were responsible for keeping the premises clean and tidy. And they regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. And its team is friendly and helpful. Members of the pharmacy team mostly dispose of people's unwanted medicines properly. And they generally carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it stores most of them appropriately and securely.

Inspector's evidence

The pharmacy had a wide entrance which was level with the outside pavement. And its door was automated. These things made it easier for people with pushchairs or who used wheelchairs or mobility scooters to enter the building. The pharmacy had some notices that told people about the services it delivered. And it had a small seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. Its team knew when a new CPCS referral had been made as a light connected to the pharmacy's computer started to flash. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. Members of the pharmacy team were friendly and helpful. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines safely. The pharmacy had the anaphylaxis resources it needed for its flu jab service. And the pharmacists who vaccinated people were appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. But the RP didn't ask another team member to check that the correct vaccine had been selected before they administered it. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. But it didn't always provide patient information leaflets for all the medicines it supplied. So, people sometimes didn't have all the information they needed to make sure they took their medicines safely. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But assembled CD prescriptions awaiting collection weren't routinely marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its

medicines and medical devices within their original manufacturer's packaging. But some medicines weren't. This made it difficult for the pharmacy team to tell if it had all the information needed if a particular make of medicine was recalled. Members of the pharmacy team marked products which were soon to expire. And they checked the expiry dates of medicines before they dispensed them and at regular intervals. But they didn't always have the time to record when they had done these. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But this was full. And the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took when a drug alert was received. But they couldn't demonstrate what records were kept showing these had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And it mostly uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had equipment for counting loose tablets and capsules too. And it had a range of glass measures to measure out liquids. But these needed to be descaled. Members of the pharmacy team had access to up-to-date reference sources. And they could contact Numark or the superintendent pharmacist for information and guidance. The pharmacy team could check a person's BP. And the monitor it used for this service was recently replaced. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. The pharmacy restricted access to its computers, its patient medication record system and the mobile phone application its team used for its delivery service. And only authorised team members could use these when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. But it could do more to make sure its team members store their NHS smartcards securely when they weren't working.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.